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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
09/972,129	10/04/2001	Arthur Gelber	840-008.002	3661

4955 7590 03/02/2006

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EXAMINER	
COBANOGLU, DILEK B	
ART UNIT	**PAPER NUMBER**
3626	

DATE MAILED: 03/02/2006

Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary	Application No.	Applicant(s)	
	09/972,129	GELBER, ARTHUR	
	Examiner	Art Unit	
	Dilek B. Cobanoglu	3626	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *04 October 2001*.

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *1-18* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *1-18* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).

11)☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

12)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____.

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO-1449 or PTO/SB/08) Paper No(s)/Mail Date _____.
4) ☐ Interview Summary (PTO-413) Paper No(s)/Mail Date. _____.
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: _____.

DETAILED ACTION

1. Claims 1 to 18 have been examined.

Claim Rejections - 35 USC § 102

2. The following is a quotation of the appropriate paragraphs of 35 U.S.C. 102 that form the basis for the rejections under this section made in this Office action:

> A person shall be entitled to a patent unless –
>
> (e) the invention was described in (1) an application for patent, published under section 122(b), by another filed in the United States before the invention by the applicant for patent or (2) a patent granted on an application for patent by another filed in the United States before the invention by the applicant for patent, except that an international application filed under the treaty defined in section 351(a) shall have the effects for purposes of this subsection of an application filed in the United States only if the international application designated the United States and was published under Article 21(2) of such treaty in the English language.

3. Claims 1-4, 9-18 are rejected under 35 U.S.C. 102(e) as being unpatentable by Provost et al. (U.S. Patent No. 6,341,265).

A. As per clai m 1, Provost et al. discloses a rules-based benefit claim pre-adjudication method for maximizing service provider/medical facility administrative and clinical efficiencies comprising the steps of:

i. generating a patient benefits plan at the service provider/medical facility location (Provost et al.; col.3, lines 24-30 and col.5, line 66 to col. 6, line 6);

ii. defining the treatments and conditions of a patient claim for benefits (Provost et al.; col.3, line 66 to col. 4, line 4);

iii. analyzing the patient claim for benefits to generate a preliminary EOB and to determine medical necessity protocols as defined by patient benefit plan and PIC standards (Provost et al.; col.3, lines 46-54);

iv. verifying compliance of treatments and conditions in the patient claim for benefits with applicable standards (Provost et al.; col.4, lines 7-21);

v. predetermining monetary allowance for medical services rendered based upon applicable payment schedules (Provost et al.; col.4, lines 39-51); and

vi. submitting the pre-adjudicated claim to a designated payer in accordance with the patient benefit plan (Provost et al.; col.4, lines 46-54).

B. As per clai m 2, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 1, further including the step of mapping data elements originating in the medical community to EOB data elements originating in the PIC universe to complete a patient benefits plan to determine the internal protocols of the PIC (Provost et al.; col.6, lines 12-21).

C. As per claim 3, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 2, further including the step of applying coding initiatives defining treatments interactively or batch with the RBS applicable standards to assure the likelihood of acceptance of a claim for payment (Provost et al.; col.6, lines 2-6).

D. As per claim 4, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying medical necessity treatments and diagnoses linkages coding appropriateness interactively or batch with the RBS applicable standard to assure the likelihood of acceptance of a claim for payment (Provost et al.; col.6, lines 2-11 and col.9, lines 53-58).

E. As per clai m 9, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, including the step of applying Medicare correct-coding initiative to the rules-based adjudication system (Provost et al.; col.9, lines 53-58).

F. As per claim 10, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying proprietary benefit plan specific coding initiatives to the rules-based pre-adjudication system (Provost et al.; col.9, lines 53-58).

G. As per claim 11, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying insurance company or benefit plan administrator's utilization standards to the rules-based pre-adjudication system (Provost et al.; col.2, lines 3-10).

H. As per claim 12, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of validating benefits plan specific medical necessity coding linkages and rules to the rules-based pre-adjudication system (Provost et al.; col.4, lines 12-16).

I. As per claim 13, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying terms and conditions of agreements between a service provider/medical facility and a managed care organization/insurance company to the rules-based pre-adjudication system (Provost et al.; col.4, lines 12-16).

J. As per claim 14, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of re-pricing services rendered at a service provider/medical facility according to a managed care or non-managed care fee schedule (Provost et al.; col.4, lines 39-46).

K. As per clai m 15, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 1, wherein the step of defining treatments and conditions further includes the steps of:

i. validating patient's information data content (Provost et al.; abstract and col.3, lines 48-55);

ii. applying a proprietary claim editor using a relational database comprising coding tables to identify appropriate procedural and diagnostic codes and applicable linkages (Provost et al.; col.6, lines 2-11, lines 54-58 and col. 9, lines 53-58).

L. As per claim 16, Provost et al. discloses a rules-based system for pre-adjudication of a benefits claim, said system comprising:

i. a source of claim data capable of identifying patient demographics and benefits plan coverage (Provost et al.; col.8, lines 33-36 and lines 53-58);

ii. means at a benefit provider site for accessing the claim data source to capture historical claim data and update patient's current information (Provost et al.; col.3, line 66 to col. 4, line 24);

iii. at least one set of pre-adjudication rules corresponding to the type of patient benefits plan coverage (Provost et al.; col.4, lines 39-51); and

iv. audit processing means for validating in accordance with said at least one set of pre-adjudication rules treatments and conditions coding and identifying applicable related treatments and conditions codes corresponding to the patient's diagnosis and prior treatment history to generate a suggested treatment plan to the provider whereby treatments are matched with conditions and applicable excluded treatments codes are identified (Provost et al.; col.5, line 66 to col.6, line 21).

M. As per claim 17, Provost et al. discloses the rules-based system for pre-adjudication of a benefits claim as defined in claim 16, wherein said audit processing means further includes means for comparing, in accordance with said at least one set of pre-adjudication rules, historical PIC-generated EOB results with submitted treatments codes and matched treatments and conditions codes and applicable excluded treatments codes to generate a suggested treatment

plan at a more successful payment rate (Provost et al.; col.5, line 66 to col.6, line 11).

N. As per claim 18, Provost et al. discloses a method for pre-adjudication of benefits claim submission to a payer, said method comprising the steps of:

i. preparing benefits claim data including identifying a patient, an insured covering the patient, benefit policy and plan codes applicable to the patient and treatments codes corresponding to conditions performed on the patient by a provider (Provost et al.; col.3, lines 24-30 and col.5, line 66 to col. 6, line 6);

ii. analyzing the benefits claim data in accordance with at least one set of predefined rules for conformity of claim data elements to a set of pre-established criteria (Provost et al.; col.3, lines 46-54);

iii. validating the treatments and conditions codes specified in the benefits claim data (Provost et al.; col.5, line 66 to col.6, line 6 and col. 9, lines 53-58);

iv. verifying that the correct coding initiatives comply with the benefits policy and plan code identified in the benefits claim data preparation step (Provost et al.; col.5, line 66 to col. 6, line 6);

v. valuating each benefit associated with the specified treatments and conditions codes (Provost et al.; col.5, line 66 to col. 6, line 11);

vi. reviewing each identified benefit value in accordance with the Policy Issuing Company agreement terms and conditions and generating

a corresponding acceptance message or correction request message (Provost et al.; col.3, lines 24-30 and col.5, line 66 to col. 6, line 6);

vii. forwarding the benefits claim to the Policy Issuing Company identified in the benefit claim data preparation step (Provost et al.; col.6, lines 12-21);

viii. presenting the benefits claim to the Policy Issuing Company for generation of an EOB in response to the benefit claim complying with the claim request requirements or in response to provider instructions (Provost et al.; col.3, lines 46-55);

ix. reviewing the PIC-generated EOB to capture remark codes to determine priority of action and generating corresponding trigger messages in response thereto and identifying rule deviations corresponding to benefits claim payments made and non-payment of qualifying benefits claim (Provost et al.; col. 5, line 66 to col.6, line 11);

x. updating said at least one set of predefined rules to incorporate changes resulting from the PIC-generated EOB review step (Provost et al.; col.4, lines 22-38); and

xi. generating messages reflecting priority of benefits claim coding to maximize provider reimbursement (Provost et al.; col.6, lines 12-21).

Claim Rejections - 35 USC § 103

4. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

5. Claims 5 to 8 are rejected under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Doyle Jr. et al. (U.S. Patent No. 4,916,611).

A. As per clai m 5, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 4, further including the steps of:

i. analyzing a PIC-generated EOB for the benefit claim submitted (Provost et al.; col.9, lines 7-14);

ii. identifying treatments and conditions paid at a different rate than that determined in the pre-adjudicated claim submitted (Provost et al.; col.10, line 66 to col. 11, line5);

iii. identifying exception treatments and conditions qualifying for reimbursements; and

iv. updating the patient benefit plan and rules-based pre-adjudication applicable standards to incorporate the analyzed PIC-generated EOB information whereby the rules-based pre-adjudication system is self-regulating (Provost et al.; col.10, line 66 to col. 11, line5).

Provost et al. fails to expressly teach identifying exception treatments and conditions qualifying for reimbursements, per se, since it appears that Provost et al. is more directed to informing the provider that the recommended treatment is not approved for

payment so that provider can advise the patient and decide to proceed or prescribe another treatment (Provost et al.; col.10, line 66 to col. 11, line5). However, this feature is well known in the art, as evidenced by Doyle Jr. et al.

In particular, Doyle Jr et al discloses a computerized systems for processing insurance claims wherein the database includes a roster of all persons having insurance benefits and particular treatments which are reimbursable by insurance (Doyle Jr. et al; col. 1, line 68 to col. 2, line 6).

It would have been obvious to one having ordinary skill in the art at the time of the invention to have combined the informing the provider that the recommended treatment is not approved for payment with the database includes a roster of all persons having insurance benefits and particular treatments which are reimbursable by insurance with the motivation of the treating physician be ascertain whether a proposed treatment is reimbursable. (Doyle Jr. et al; col. 2, lines 6-16).

B. As per clai m 6, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 5, further including the step of analyzing historical PIC-generated EOBs for other patients in accordance with the updated patient benefits plan to identify additional qualifying treatments and conditions not previously claimed and submitted or previously claimed and rejected.

The obviousness of modifying the teaching of Provost et al. to include the roster of all persons having insurance benefits and particular treatments which are reimbursable by insurance (as taught by Doyle Jr. et al) is as addressed above in the rejection of claim 5 and incorporated herein.

C. As per claim 7, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 5, further including the step of analyzing historical PIC-generated EOBs for other patients by ZIP code to identify treatments and conditions qualifying for reimbursement for some patients and not other patients within a given patient's benefits plan, and submitting a benefit claim for the unpaid identified treatments and conditions qualifying for reimbursement.

Provost et al. fails to expressly teach analyzing historical PIC-generated EOBs for other patients by ZIP code or location, per se, since it appears that Provost et al. is more directed to preparing and then submitting an insurance claim to receive almost immediately an indication whether the submitted claim is in condition to be paid (Provost et al.; col.3, lines 25-30). However, this feature is well known in the art, as evidenced by Doyle Jr. et al. In particular, Doyle Jr et al discloses computerized systems for processing insurance claims, wherein a physician, at the time and location of rendering medical treatment, obtains information as to the amount of payment (Doyle Jr. et al; col. 10, lines 10-13).

It would have been obvious to one having ordinary skill in the art at the time of the invention to have combined the preparing and then submitting an insurance claim to receive almost immediately an indication whether the submitted claim is in condition to be paid with the physician obtaining information as to the amount of payment, at the time and location of rendering medical treatment, with the motivation of the treating physician be ascertain whether a proposed treatment is reimbursable. (Doyle Jr. et al; col. 2, lines 6-16).

D. As per claim 8, Provost et al. discloses the rules-based benefit claim pre-adjudication method as defined in claim 5, further including the steps of:

i. analyzing historical PIC-generated EOBs for other patients by different ZIP codes to identify treatments and conditions qualifying for reimbursement for some patients and not other patients within a given patient's benefits plan;

ii. advising a service provider/medical facility having a potential qualifying benefit claim for a previous unclaimed or rejected claim for a patient in the given patient's benefits plan; and

iii. submitting the potential qualifying benefit claim for reimbursement (Provost et al.; col.4, lines 46-54).

The obviousness of modifying the teaching of Provost et al. to include the physician obtaining information as to the amount of

payment, at the time and location of rendering medical treatment (as taught by Doyle Jr. et al) is as addressed above in the rejection of claim 7 and incorporated herein.

Conclusion

6. The prior art made of record and not relied upon is considered pertinent to applicant's disclosure. The cited but not used prior art teach "System and method for detecting fraudulent medical claims via examination of service codes" 5,253,164 A, "Prescription management system" 5,845,255 A, "Computer software for processing medical billing record information" 5,933,809 A, "Personal injury claim management system" 5,956,687 A, "System and method for predicting, comparing and presenting the cost of self insurance versus insurance and for creating bond financing when advantageous" 6,009,402 A, "System and method for supporting delivery of health care" 6,012,035 A, "Apparatus and method for determining insurance benefit amounts based on groupings of long-term care patients with common characteristics" 6,014,632 A, "System and method for replacing a liability with insurance and for analyzing data and generating documents pertaining to a premium financing mechanism paying for such insurance" 6,026,364 A, "Systems, methods and computer program products for identifying unique and common legal requirements for a regulated activity among multiple legal jurisdictions" 6,064,968 A, "Apparatus and method of composing a plan of flexible benefits" 6,092,047 A, "Computer apparatus and method for generating documentation using a computed value for a claims cost affected by at least one concurrent, different insurance policy for the same insured" 6,163,770 A, "Electronic

creation, submission, adjudication, and payment of health insurance claims" 6,343,271 B1.

7. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Dilek B. Cobanoglu whose telephone number is 571-272-8295. The examiner can normally be reached on 8-4:30.

8. If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on 571-272-6776. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

9. Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).

DBC

Ms. Dilek B. Cobanoglu
Art Unit 3626

JOSEPH THOMAS
SUPERVISORY PATENT EXAMINER